

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155219		X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED 08/19/2013	
NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF SOUTH BEND				STREET ADDRESS, CITY, STATE, ZIP CODE 52654 N IRONWOOD RD SOUTH BEND, IN 46635			
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K010000	<p>A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a).</p> <p>Survey Date: 08/19/13</p> <p>Facility Number: 000124 Provider Number: 155219 AIM Number: 100266730</p> <p>Surveyor: Mark Caraher, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Signature Healthcare of South Bend was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), and 410 IAC 16.2.</p> <p>This one story facility was determined to be of Type V (111) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors and in all areas open to the corridor. The facility smoke detectors hard wired to the fire alarm system installed in all resident sleeping rooms.</p>		K010000	<p>The facility requests that this plan of correction be considered its credible allegation of compliance. Submission of this response and Plan of Correction is not a legal admission that a deficiency exists or that this statement of deficiency was correctly cited, it is also not to be construed as an admission of interest against the facility, the administrator, or any employee, agents, or others who draft or may be discussed in response and Plan of Correction. In addition, preparation and submission of the POC does not constitute an admission or agreement of any kind by the facility of truth of any facts alleged or the correction of conclusions set forth in this allegation by the survey agency. Accordingly, the facility has prepared and submitted this plan of correction prior to the resolution of appeal of this matter solely because of the requirements under State and Federal law mandates submission of the Plan of Correction condition to participate in Title 18 and 19 programs. The submission of the POC within this timeframe should in no way be of non-compliance or an admission by the facility. The facility requests a desk review all audit tools will be provided when requested.</p>			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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	<p>The facility has a capacity of 157 and had a census of 100 at the time of this survey.</p> <p>All areas where residents have customary access were sprinklered. The facility has one detached garage providing facility storage services which was fully sprinklered and one wooden storage shed which was not sprinklered.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 08/21/13.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p>						

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K010038 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1</p> <p>Based on observation and interview, the facility failed to ensure the means of egress through 1 of 15 delayed egress locks in the facility was readily accessible for residents, staff and visitors. LSC 7.2.1.6.1, Delayed Egress Locks, says approved, listed, delayed egress locks shall be permitted to be installed on doors serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system installed in accordance with Section 9.6, or an approved, supervised automatic sprinkler system installed in accordance with Section 9.7, and where permitted in Chapters 12 through 42, provided: (c) An irreversible process shall release the lock within 15 seconds upon application of a force to the release device required in 7.2.1.5.4 that shall not be required to exceed 15 lbf nor required to be continuously applied for more than 3 seconds. The initiation of the release process shall activate an audible signal in the vicinity of the door. Once the door lock has been released by the application of force to the releasing device, relocking shall be by manual means only. Exception: Where approved by the authority having jurisdiction, a</p>	K010038	<p>K038 –1. Identified egress door has been repaired to allow exit per regulation. 2. All residents have the potential to be affected. 3. Maintenance director or designee will perform monthly preventative maintenance review of all exits to ensure regulatory compliance.4. Preventative maintenance reports will be reviewed monthly in Performance Improvement meeting x 3 months and quarterly thereafter to maintain compliance.5. Compliance is assured by September 18, 2013.</p>		09/18/2013		

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	<p>delay not exceeding 30 seconds shall be permitted.</p> <p>This deficient practice could affect 5 residents, staff and visitors wanting to exit the facility using the set of exit doors by the Ambulance Bay.</p> <p>Findings include:</p> <p>Based on observation with the Executive Director and the Plant Operations Director during a tour of the facility from 1:20 p.m. to 4:50 p.m. on 08/19/13, the set of exit doors by the Ambulance Bay is equipped with a delayed egress lock and was provided with signage stating the door could be opened in 15 seconds by pushing on the door with the application of force to the release device within 15 seconds but the exit door did not release within 15 seconds when the door was pushed with the application of force three separate times. Based on interview at the time of observation, the Plant Operations Director acknowledged the set of exit doors by the Ambulance Bay is equipped with a delayed egress lock which was provided with signage stating the door could be opened in 15 seconds by pushing on the door with the application of force to the release device within 15 seconds but the exit door did not release within 15 seconds when the door was pushed with the application of force three separate</p>						

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	times. 3.1-19(b)						

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K010046 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Emergency lighting of at least 1½ hour duration is provided in accordance with 7.9. 19.2.9.1.</p> <p>Based on observation and interview, the facility failed to provide exterior emergency lighting of at least 1½ hour duration for 1 of 15 exits. LSC Section 7.9.1.1 requires emergency lighting facilities for means of egress shall be provided for the exit access and exit discharge. This deficient practice could affect 52 residents, staff and visitors if required to evacuate the facility from the exit by the Beauty Shop.</p> <p>Findings include:</p> <p>Based on observation with the Executive Director and the Plant Operations Director during a tour of the facility from 1:20 p.m. to 4:50 p.m. on 08/19/13, the exit by the Beauty Shop exit discharge to the exterior of the facility was not provided with exterior lighting. Based on interview at the time of observation, the Executive Director and the Plant Operations Director acknowledged the aforementioned exit discharge to the exterior of the facility was not provided with exterior lighting.</p> <p>3.1-19(b)</p>	K010046	<p>K046-1. Identified exterior lighting will be installed per regulation. 2. All residents are potentially affected. 3. Maintenance director or designee will audit exterior lighting at exits through monthly preventative maintenance program 4. Preventative maintenance reports will be reviewed monthly x 3 months and quarterly thereafter to ensure regulatory compliance. 5. Compliance is assured by September 18, 2013</p>		09/18/2013		

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K010062 SS=C	<p>NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5</p> <p>1. Based on record review, observation and interview; the facility failed to ensure 1 of 1 automatic sprinkler systems was continuously maintained in reliable operating condition and inspected and tested periodically. NFPA 25, at Table 5-1.1 states the inspection and maintenance schedule for fire pump assemblies. Section 6-1 contains inspection, testing and maintenance requirements for water storage tanks. Section 5-5.1 states a preventive maintenance program shall be established on all components of the fire pump assembly in accordance with the manufacturer's recommendations. Records shall be maintained on all work performed. Section 1-8 states records of inspections, tests and maintenance shall be made available to the authority having jurisdiction upon request. This deficient practice affects all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on review of Koorsen Fire & Security "Service Work Order"</p>		K010062	<p>K062- 1. Fire pump and fire hydrant will be inspected by qualified technician to determine status of operation. Fire Hydrant will be flushed per regulation. And spare sprinkler heads will be provided in compliance with regulation. 2. All residents were potentially affected by this practice. 3. Fire hydrants will be inspected annually per regulation. Maintenance director will maintain records of annual inspections. Maintenance director or design will review through preventative maintenance program that spare sprinkler heads are available per regulation. 4. Preventative maintenance reviews of fire hydrant, pump and spare sprinkler heads will be reviewed quarterly in Performance Improvement to ensure compliance. 5. Compliance is assured by September 18, 2013</p>		09/18/2013	

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	documentation dated 11/30/11 and "Invoice" documentation dated 12/30/11 during record review with the Plant Operations Director from 10:45 a.m. to 12:50 p.m. on 08/19/13, the most recent fire pump service stated "Bypass fire pump monitor points," "reset tamper in fire pump building" and "Fire pump labor service." Item #3 of Koorsen's quarterly sprinkler system "Inspection and Test Report" documentation dated 06/17/13 stated "DNA" to "Are fire pumps in good condition and required test performed if needed." Based on observation with the Executive Director and the Plant Operations Director during a tour of the facility from 1:20 p.m. to 4:50 p.m. on 08/19/13, a fire pump and a water storage tank for the facility sprinkler system was observed in the detached garage which was sprinklered. Based on interview at the time of record review and of the observation, the Plant Operations Director stated he was unaware the facility had a fire pump and water storage tank, whether either device was operable and acknowledged no written preventive maintenance plan and no weekly and annual fire pump documentation was available for review. In addition, e-mail correspondence from the facility dated 08/21/13 stated the "fire pump was bypassed in 2011 for a trouble alert to reset the tamper, if it is still bypassed we						

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	<p>don't know" and "fire pump may not be operational."</p> <p>3.1-19(b)</p> <p>2. Based on record review, observation and interview; the facility failed to ensure 1 of 1 private fire hydrants were continuously maintained in reliable operating condition and inspected and tested periodically. NFPA 25, 1998 Edition, the Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems at Section 4-2.2.4 requires dry barrel hydrants to be inspected annually and after each operation. Hydrants shall be inspected, and the necessary corrective action shall be taken. This deficient practice could affect all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on review of Clay Fire Territory "Hydrant Flow Test by Hydrant" documentation dated 03/01/11 with the Director of Plant Operations during record review from 10:45 a.m. to 12:50 p.m. on 08/19/13, an inspection of the facility's one fire hydrant was not performed within the last twelve months. Based on interview at the time of record review, the Maintenance Director stated no other fire hydrant inspection</p>						

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	<p>documentation was available for review, the fire hydrant is not owned by the City of South Bend and acknowledged it has been more than twelve months since the last annual inspection of the one fire hydrant. Based on observation with the Executive Director and the Plant Operations Director during a tour of the facility from 1:20 p.m. to 4:50 p.m. on 08/19/13, one fire hydrant was located by the detached garage.</p> <p>3.1-19(b)</p> <p>3. Based on observation and interview, the facility failed to provide a complete supply of spare sprinklers for the automatic sprinkler system in accordance with NFPA 25, 1998 Edition, the Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. Section 2-4.1.4 requires a supply of at least six spare sprinklers shall be stored in a cabinet on the premises for replacement purposes. The stock of spare sprinklers shall be proportionally representative of the types and temperature ratings of the system sprinklers. A minimum of two sprinklers of each type and temperature rating installed shall be provided. This deficient practice could affect all residents, staff and visitors if the sprinkler system had to be shut down because a proper sprinkler</p>						

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	<p>wasn't available as a replacement.</p> <p>Findings include:</p> <p>Based on observation with the Executive Director and the Plant Operations Director during a tour of the facility from 1:20 p.m. to 4:50 p.m. on 08/19/13, one white color coded upright spare sprinkler, one blue color coded spare sprinkler and one sidewall spare sprinkler were located in the spare sprinkler cabinet at the sprinkler riser in the Maintenance Office. White color coded upright sprinkler heads were observed installed in the penthouse of the Mechanical Room and sidewall sprinkler heads were observed located in the Ambulance Bay. No blue color coded sprinkler heads were observed installed in the facility. Based on interview at the time of observation, the Plant Operations Director acknowledged a minimum of two spare sprinklers of each type and temperature rating were not located on the premises or in the spare sprinkler cabinet.</p> <p>3.1-19(b)</p>						

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K010144 SS=F	<p>NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1.</p> <p>1. Based on record review and interview, the facility failed to ensure a monthly load test for the emergency generator was conducted for 4 of 12 months using one of the three following methods: under operating temperature conditions, at not less than 30% of the Emergency Power Supply (EPS) nameplate rating, or loading which maintains the minimum exhaust gas temperatures as recommended by the manufacturer. Chapter 3-4.4.1.1 of NFPA 99 requires monthly testing of generators serving the emergency electrical system to be in accordance with NFPA 110. Chapter 6-4.2 of NFPA 110 requires generator sets in Level 1 and Level 2 service to be exercised at least once monthly, for a minimum of 30 minutes, using one of the following methods:</p> <p>a. Under operating temperature conditions or at not less than 30 percent of the EPS nameplate rating.</p> <p>b. Loading that maintains the minimum exhaust gas temperatures as recommended by the manufacturer.</p> <p>The date and time of day for required testing shall be decided by the owner, based on facility operations. This deficient practice could affect all</p>	K010144	<p>K-144 Generator and Generator Annunciator panels will be inspected and repaired as needed by qualified technician. Any deficient findings will be addressed immediately by maintenance director or designee. All residents were potentially affected. Maintenance director or designee will perform monthly preventative maintenance review of generator and Generator Annunciator panels to ensure functionality per regulation. Preventative Maintenance reports will be reviewed monthly in Performance Improvement Meeting x 3 months and quarterly thereafter to ensure compliance. Compliance is assured by September 18, 2013.</p>		09/18/2013		

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	<p>residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on review of "Emergency Generator-Monthly Log Sheet " documentation for 2012 and 2013 with the Plant Operations Director during record review from 10:45 a.m. to 12:50 p.m. on 08/19/13, monthly load test documentation for November and December 2012 and for March and May 2013 did not include if the emergency generator ran under operating temperature conditions, at not less than 30% of the EPS nameplate rating, or loading that maintains the minimum exhaust gas temperatures as recommended by the manufacturer. The aforementioned monthly load test documentation each indicated the "KW load" of the test was less than 30%. Based on interview at the time of record review, the Plant Operations Director acknowledged November and December 2012 and March and May 2013 monthly load test documentation did not include if the emergency generator ran under operating temperature conditions, at not less than 30% of the EPS nameplate rating, or loading that maintains the minimum exhaust gas temperatures as recommended by the manufacturer.</p>						

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	<p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to ensure 1 of 2 annunciator panels for the emergency generator would alert staff to generator alarm conditions in accordance with NFPA 99, 1999 Edition, Standard for Health Care Facilities. NFPA 99, Section 3-4.1.1.15 requires a remote annunciator to be provided in a location readily observed by operating personnel at a regular work station. The annunciator shall indicate alarm conditions of the emergency or auxiliary power source as follows:</p> <p>a. Individual visual signals shall indicate the following:</p> <ol style="list-style-type: none"> 1. When the emergency or auxiliary power source is operating to supply power to load 2. When the battery charger is malfunctioning <p>b. Individual visual signals plus a common audible signal to warn of an engine-generator alarm condition shall indicate the following:</p> <ol style="list-style-type: none"> 1. Low lubricating oil pressure 2. Low water temperature (below those required in 3-4.1.1.9) 3. Excessive water temperature 4. Low fuel - when the main fuel storage tank contains less than a 3-hour operating supply 						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155219		X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED 08/19/2013	
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	<p>5. Overcrank (failed to start)</p> <p>6. Overspeed</p> <p>Where a regular work station will be unattended periodically, an audible and visual derangement signal, appropriately labeled, shall be established at a continuously monitored location. This derangement signal shall activate when any of the conditions in 3-4.1.1.15(a) and (b) occur, but need not display these conditions individually.</p> <p>In addition, NFPA 101 at Section 4.6.12.1 requires any device, equipment or system required for compliance with this Code shall be continuously maintained. This deficient practice could affect all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on observation with the Executive Director and the Plant Operations Director during a tour of the facility from 1:20 p.m. to 4:50 p.m. on 08/19/13, the facility has two emergency generator annunciator panels with one panel located in the Maintenance Office and one panel located at the North Nurses' Station. The emergency generator annunciator panel located at the North Nurses Station did not function when the test button was pushed. In addition, the North Nurses Station emergency generator annunciator panel did not function when the</p>						

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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	<p>emergency generator was started and commenced operation at 2:45 p.m. Based on interview at the time of observation, the Plant Operations Director stated the emergency generator annunciator panel located in the Maintenance Office is not located in area which is continuously monitored and acknowledged the emergency generator annunciator panel located at the North Nurses Station was not functioning.</p> <p>3.1-19(b)</p>						